CHAPTER IV
NURSING FACILITY AND WAIVER SERVICES

CHAPTER IV
TABLE OF CONTENTS

CHAPTER IV

GENERAL SCOPE OF PROGRAM

Nursing facility pre-admission screening is a process to:

- Evaluate the medical, nursing, developmental, psychological, and social needs of each individual believed to be in need of *or* at risk of nursing facility admission;
- Analyze what specific services the individual needs;
- Evaluate whether a service or a combination of existing community services is available to meet the individual's needs; and
- Determine the level of care required by the individual by applying existing criteria for nursing facility.

The pre-admission screening process is designed to be a team process that includes the input of both medical and social work professionals. The screening team's assessment of the availability of community services depends upon:

- Whether the needed service exists in the community;
- Whether financial eligibility for Medicaid coverage can be established; and
- Whether the service can be delivered at the time and in the amount necessary to meet the individual's needs.

The screening team explores alternative settings or services, or both, which might meet the identified needs of the individual. If nursing facility placement or a combination of other services is determined to be appropriate, the screening team initiates referrals for service. If Medicaid-funded home and community-based care services are determined to be necessary to delay or avoid nursing facility placement, the screening team is responsible for assisting in the development an appropriate Service Plan and initiating referrals for service.

PROGRAM BACKGROUND - LEGAL BASIS

Pre-admission screening was implemented in Virginia in 1977 to ensure that Medicaid-eligible individuals placed in nursing facilities actually require nursing facility care. In 1982, § 32.1-327.2 (re-codified at § 32.1-330) of the Code of Virginia was revised to require pre-admission screening for all individuals who will be eligible for community or institutional long-term care. Section 32.1-330 of the Code of Virginia currently states:

> § **32.1-330**. **Preadmission screening required.** -- All individuals who will be eligible for community or institutional long-term care services as defined in the state plan for medical assistance shall be evaluated to determine their need for nursing facility services as defined in that plan. The Department shall require a pre-admission screening of all individuals who, at the time of application for

> admission to a certified nursing facility as defined in § 32.1-123, are eligible for medical assistance or will become eligible within 180-days following admission. For community-based screening, the screening team shall consist of a nurse, social worker and physician who are employees of the Department of Health or the local department of social services. For institutional screening, the Department shall contract with acute care hospitals.

(Please note that section 32.1-330 was further amended by the 2003 General Assembly. A description of the amendment is set forth below.)

Pre-admission screening determines whether an individual needs nursing facility services and, when appropriate, authorizes either nursing facility or community-based long-term care. Pre-admission screening is the first level of authorization for Medicaid reimbursement for nursing facility level of care or for certain Home and Community-Based Care Waiver Services.

Community-Based Care Waiver services can be authorized as an alternative to nursing facility care only when the individual meets the level of care criteria and is at risk of nursing facility placement. "At risk" is defined as needing services within 30 days or less.

Section 32.1-330 was further revised in 2003, to provide that, effective July 1, 2003, Woodrow Wilson Rehabilitation Center will be able to complete their own pre-admission screening documents for individuals transferring out of their facility to either nursing facility placement or placement in one of our home and community based care waivers.

Mental Illness, Mental Retardation, and/or Related Condition Screenings

The Omnibus Budget Reconciliation Act (OBRA) of 1987, Part 2, Subtitle C of Title IV, added § 1919 to the Social Security Act. Section 1919 (e)(7) requires states to have pre-admission screening programs to identify individuals with mental illness, mental retardation, or a related condition using criteria established by the Secretary of Health and Human Services. Specifically, § 1919(b)(3)(F) prohibits a nursing facility from admitting any new resident who has mental illness, mental retardation, or a related condition unless that individual has been determined by the State Mental Health (MHA) or Mental Retardation Authority (MRA) to require the level of services provided by a nursing facility. If so, the State Mental Health or Mental Retardation Authority will determine whether active treatment is required. Therefore, Virginia's Nursing Facility Pre-Admission Screening Program includes the participation of mental health professionals from the local community services boards and a representative from the State Mental Health and Mental Retardation Authority (the Department of Mental Health, Mental Retardation and Substance Abuse Services) in those cases where mental illness, mental retardation, or related conditions are a factor.

There is an additional screening component in place for individuals with a diagnosis of Mental Illness (MI), Mental Retardation (MR) and/or a Related Condition (RC). The DMAS-95 MI/MR Level I mental illness (MI), mental retardation (MR) or related condition (RC) screening is the first step to identify MI/MR/RC for individuals seeking nursing facility placement. The Level II MI/MR/RC screening determines if the individual may benefit from additional specialized services but does not preclude them from receiving services in a nursing facility or a home and community-based care waiver that has a nursing facility as the alternative institutional

placement. In those cases in which the screening team determines that the individual requires assessment for conditions of MI, MR, or RC, the screening team will refer for a Level II assessment for nursing facility placement to the appropriate contractor hired by the State MH/MRA.

The DMAS-101A is the first step to identify MI/MR/RC for individuals seeking placement in one of Virginia's home and community-based care waiver programs. The DMAS-101B screening determines if the individual may benefit from additional specialized services. For home and community-based care waiver services the individual is referred to the Community Services Board (CSB), which will become involved with the screening team in determining the appropriate placement authorization.

Exception: Individuals with a condition of AIDS or who are HIV+ and symptomatic are exempt from the requirement for a Level II assessment for conditions of mental illness, mental retardation, or related conditions, due to the terminal nature of their illness. Individuals with AIDS or who are HIV+ and symptomatic are also exempt from the 101A screening process for the waivers related to Mental Illness, Mental Retardation, and/or Related Conditions.

HOME AND COMMUNITY-BASED CARE

The philosophy of the Commonwealth of Virginia is that individuals should have a choice of settings for health care delivery whenever possible, thereby not being restricted to nursing facility placement for the receipt of health care. Medicaid-funded home- and community-based care is an alternative to institutional placement, which must be approved under special waiver authority by the United States Secretary of Health and Human Services. Approval of Virginia's home- and community-based care waivers is also contingent upon projections, for each year of the waiver, of the number of recipients the Commonwealth expects to receive waiver services and the average per capita expenditures projected for waiver services.

Virginia has several home- and community-based care waivers, which use the nursing facility Pre-Admission Screening Program (NHPAS) as the prior assessment and authorization for receipt of waiver services. They are: the Elderly and Disabled (E&D) Waiver, the Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Waiver, the Consumer-Directed Personal Assistance Services Waiver.

For individuals 21 years of age or older, who want services through the Technology Assisted Waiver, a pre-admission screening is completed by the community screening team when the individual is at home, or a licensed clinical social worker (LCSW) if he or she is in a nursing facility or institution. The completed screening is then sent to the Health Care Coordinator (HCC) at DMAS for evaluation of waiver eligibility and authorization of waiver services.

If the individual is under 21 years old, an assessment is completed by a LCSW and a medical professional (either a RN or physician) when he or she resides a nursing facility or medical institution. If the child is at home when requesting waiver services, the HCC will make a home visit to complete the assessment and determine if the individual meets eligibility criteria. If the recipient meets eligibility criteria, the services are authorized by the HCC.

Individuals entering the Pre-PACE or PACE program and individuals residing in the community

requesting placement in the technology assisted waiver program are also subject to NHPAS by the local screening teams.

To ensure that the above mentioned Virginia's Home- and Community-Based Care Waiver programs serve only individuals who would otherwise require institutional care, community-based care services can be considered only for individuals who meet the state's established criteria for nursing facility or are at risk of hospital placement if the individual has AIDS or HIV. Community-based care services must be the critical service that enables the individual to remain at home rather than being placed in an institution.

This manual describes the role of the screening teams in assessing an individual's needs for long-term care services and explains the Department of Medical Assistance Services' (DMAS) rules, regulations, and procedures related to nursing facility pre-admission screening. This manual is a resource and training tool for individuals who participate as screening team members.

All forms referenced in this Chapter are found in either Appendix C for HIV/AIDS Waiver or Appendix D for nursing facility and the E&D or CDPAS Waivers. Sample letters for the pre-admission screening process are found in Appendix E of this manual.

POPULATION TO BE SCREENED

Medicaid Eligible Individuals

Individuals in the community or in acute-care hospitals must be screened to determine the necessity for nursing facility placement if the individual is currently financially Medicaid-eligible or anticipates that he *or* she will be financially eligible within 180 days of the receipt of nursing facility care *or* if the individual is at risk of nursing facility placement. Individuals at risk of nursing facility placement, have several home and community-based care waiver options available to them, in addition to placement in a nursing facility. The waiver options available for individuals that meet nursing facility level of are: Elderly and Disabled, Consumer-Directed Personal Assistance Services and the AIDS/HIV waivers.

This requirement assures that all individuals who will be eligible for Medicaid payment for community or nursing facility long-term care services have been evaluated to determine the need for nursing facility level of service.

POPULATION EXCLUSIONS TO THE PRE-ADMISSION SCREENING PROCESS

Private Pay Individuals

All individuals who are applying to enter a nursing facility and who are not anticipated to be Medicaid-eligible within 180 days subsequent to nursing facility admission are considered to be private pay patients and must be assessed to determine the need for nursing facility care and the need for any active treatment for mental illness or mental retardation. The nursing facility is responsible for conducting this assessment, identifying those persons potentially having a diagnosis of mental illness or mental retardation and referring them to their private practitioners for further diagnostic evaluation. Individuals applying for admission to a nursing facility from a military hospital shall be treated as private pay patients.

The screening team is not responsible for conducting assessments for private pay patients in either the acute care or community setting and cannot receive Medicaid reimbursement for a screening of a private pay patient.

Mental Health/Mental Retardation Facilities

Individuals who are residents in state mental health and mental retardation facilities or facilities for the mentally retarded that seek nursing facility placement directly from these facilities must be screened. These screenings will be completed by DMAS in cooperation with representatives of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and, therefore, are not the responsibility of the local or acute-care screening teams.

Veterans Administration Medical Center or Other Military Hospital Facility

Individuals in Veterans Administration Medical Centers (VAMC) who are applying to enter a nursing facility will be assessed by the VAMC discharge planning staff to determine the need for nursing facility care and to identify any conditions of mental illness or mental retardation that require further Level II assessment. The VAMC discharge planning staff will use their own Veterans Administration assessment form, the Community Nursing Facility Care form, and the MI/MR supplement for the Level I assessment.

TARGET POPULATION FOR ADMISSION TO A WAIVER

Federal regulations governing Medicaid coverage of home and community-based services under an approved waiver specify that services provided under waiver authority must be targeted to individuals who otherwise might have to be in a nursing facility.

The target population for the Elderly and Disabled (E&D) Waiver or the Consumer-Directed Personal Assistance Services (C-DPAS) Waiver includes all of the following requirements:

1. Meet the Nursing Facility Level of Care Criteria, as defined in Appendix B of this manual and generally outlined in this section. The individual meets the nursing facility criteria and is at risk of nursing facility placement (as defined below) without waiver services. Waiver services are offered to such an individual as an alternative to avoid nursing facility admission;

2. Have been determined financially eligible for Medicaid coverage;

3. Are not a resident of a nursing facility or assisted living facility;

4. Has insufficient community resources *or* no other community resources available to meet his or her needs; and

5. Must have an appropriate Service Plan (DMAS-97 form) developed by the screening team.

Under the waiver for individuals with AIDS or HIV, community-based care services may be furnished only to persons:

1. Who require the level of care provided in a hospital or nursing facility or can be shown to require AIDS Waiver services to prevent future institutional services;

2. Who have been diagnosed as having AIDS or HIV by a physician and are experiencing medical and functional symptoms associated with AIDS or HIV;

3. Who are not residents of hospitals, nursing facilities, or assisted living facilities;

4. For whom an appropriate Service Plan can be developed, the cost of which is expected to be equal to or less than institutional services and which ensures the individual's safety and welfare in the home and community;

5. Who have been determined financially eligible for Medicaid coverage, and

6. Who have no other, or insufficient, community resources available to meet their needs.

Home and community-based care waiver programs are not entitlement programs and are not appropriate for every individual. Home and community-based care services can be authorized only where there is a provider agency available to meet the individual's needs. The screening team must provide individuals with a list of active providers in their area that offer services through the Medicaid funded home and community-based care waiver programs. Services may only be authorized when all other available community resources have been accessed or utilized in place of Medicaid-funded long-term care placement.

TRANSFERS

Nursing Facility Awaiting Placement

At times, an individual who has been assessed by the local screening team as appropriate for nursing facility care will have to remain in the community while waiting for a nursing facility bed. In these instances, it is appropriate for the individual to receive services through the Elderly and Disabled, Consumer-Directed Personal Assistance Services or HIV/AIDS Waivers until nursing facility placement takes place.

Nursing Facility to Hospital Transfers

Screening teams in hospitals do not complete a pre-admission screening for individuals who are admitted to a hospital from a nursing facility when the individual is to be discharged back to either the same or a different nursing facility and the individual continues to meet nursing facility level of care based upon current level of functioning.

If an individual is admitted to a hospital from a nursing facility and the individual's condition has not changed, but placement in a different nursing facility is sought, a new pre-admission screening is not required. The second nursing facility would be required to complete necessary

documentation for Medicaid admission certification.

For individuals with a diagnosis, history, or presenting evidence of mental illness, mental retardation, or related conditions, there is no need for a second Level II screening unless the individual's mental health status has changed. The screening team, when completing a second pre-admission screening on an individual with a condition of mental illness, mental retardation or related condition, must note on the DMAS-95 MI/MR form that there has been no change in that individual's mental status since the previous Level II assessment, and therefore, that assessment continues to be valid. The Level II assessment may be obtained from the nursing facility.

Nursing Facility to Waiver Transfers

When an individual is discharged from a nursing facility and is expected to receive services under one of the following Medicaid waivers, Elderly and Disabled, Consumer-Directed Personal Assistance Services or the AIDS/HIV waiver, a new pre-admission screening is not required.

If the individual was not screened prior to admission to the nursing facility, the locality in which the individual resides must complete the pre-admission screening prior to the individual receiving services under the waiver.

Nursing Facility to Nursing Facility Transfers

Individuals residing in a licensed nursing facility and desiring a transfer to another nursing facility in the Commonwealth of Virginia are not required to be screened by local or hospital screening teams. The nursing facility from which the individual is transferring must send a copy of all screening material to the receiving nursing facility. The receiving nursing facility is then responsible for initiating the appropriate documentation for admission certification purposes.

Waiver to Hospital Transfers

If an individual is admitted from a home and community-based care waiver to a hospital and is then returning home to services under the same waiver, a new pre-admission screening is not required.

For individuals with a diagnosis, history, or presenting evidence of mental illness, mental retardation, or related conditions, a DMAS-101A and DMAS-101B screening must be completed prior to receiving services under the waiver.

Waiver to Nursing Facility Transfers

An individual entering a nursing facility who anticipates Medicaid payment for his or her stay by DMAS must first be screened to determine if he or she meets established Medicaid nursing facility level of care criteria. When an individual is expected to enter a nursing facility directly from the Elderly and Disabled, Consumer-Directed Personal Assistance Services or the AIDS/HIV waiver, a new pre-admission screening is not required.

Waiver to Waiver Transfers

Individuals receiving services through the Elderly and Disabled (E&D) waiver, HIV/AIDS waiver, or Consumer-Directed Personal Attendant Services (CDPAS) waiver and desiring a transfer to another waiver, are not required to be screened by local or hospital screening teams. The servicing provider from which the individual is transferring must send a copy of all screening material to the receiving servicing provider. The receiving servicing provider is then responsible for initiating the appropriate documentation for admission certification purposes. The individual must meet the criteria for admission to any waiver for which they apply.

If an individual is in the E&D or CDPAS Waiver and wishes to transfer and receive services through the Individuals and Families with Developmental Disabilities Services Waiver or the Mental Retardation Waiver, the individual must undergo the appropriate screening for the requested waiver.

SPECIAL CIRCUMSTANCES AND TRANSFERS

Rehabilitation Hospital or Rehabilitation Units of Acute Care Hospital Transfers

The acute-care screening team is responsible for pre-admission screening assessment and authorizations for nursing facility level of care or home and community-based care services for individuals in units of acute-care hospitals.

Out-of-State Transfers and Admissions

For individuals who reside out of state and wish direct admission to a nursing facility in Virginia, a pre-admission screening is not required. The admitting nursing facility is responsible for ensuring that the individual meets the established criteria for nursing facility placement and that the Federal requirements related to MI/MR/RC are met upon admission. If not a direct admission, then the individual is subject to pre-admission screening by the locality in which the individual is residing.

For individuals who reside out of state and wish admission to home and community-based care services, the screening team in the locality in which the individual will reside must complete a pre-admission screening. The locality may screen the individual either once the individual relocates.

AUTHORIZATIONS AND REFERRALS

For Nursing Facility Authorization

The screening team may establish that nursing facility level of care is appropriate for an individual after the pre-admission screening has been completed. In the case where a documented condition of MI, MR, or RC is present and requires completion of the Level II assessment and after the State Mental Health/Mental Retardation Authority (MH/MRA) has returned the Level II evaluation assessment, the screening team can authorize nursing facility level of care.

The individual must be given the choice between nursing facility level of care and placement in one of the home and community based care waiver programs, such as the Elderly and Disabled Waiver, the Consumer-Directed Personal Assistance Services Waiver or the AIDS/HIV Waiver.

During the authorization process, the screening team will assist the individual with determining what level of care and services, if any, are needed; who will provide the services; and the setting where services will be provided. If the MH/MRA has recommended active treatment, the CSB will determine the setting for care in order to meet the active treatment needs.

If a Level II assessment indicates nursing facility level of care cannot be authorized, the screening team and MH/MRA must confer with the individual about placement options.

The screening team must inform the individual or family of all of the following requirements:

1. That the authorization for Medicaid funded services does not mean that the individual will definitely become financially Medicaid-eligible;

2. That financial eligibility for Medicaid coverage must be determined by an eligibility worker at the local department of social services;

3. That Medicaid cannot reimburse for services unless the individual has been determined to be financially Medicaid-eligible and meets the level of care criteria for service authorization; and

4. That the individual may have a financial responsibility in the form of a co-payment for Medicaid-funded services, as determined by the eligibility worker at the local department of social services.

Referrals for Nursing Facility Placement

A referral to a nursing facility can be initiated when the screening team completes an assessment, determines that an individual meets the criteria for nursing facility care and that no Level II assessment is indicated, *or* has received authorization for nursing facility care from the MH/MRA on the Level II Assessment, and DMAS community-based care services are not appropriate. The screening team will complete a DMAS-96 form and send a letter indicating the decision to the individual who was screened.

When nursing facility placement is approved, all of the following procedures apply:

1. The screening team will send the nursing facility providing the care: (a) the original UAI and DMAS-95 Level I (if appropriate Level II) MI/MR; (b) a copy of the DMAS-96 form; and (c) a copy of the DMAS-20 form.

2. The screening team will send a letter to the individual screened with a copy to the referral source indicating the decision of the team. The individual will receive appeal rights within this decision letter giving them instructions on how to appeal the screening team's decision.

3. The screening team will send a copy of the completed DMAS-96 form to the appropriate local department of social services, Eligibility Section.

4. Within 30 days of the assessment date, the screening team will send to First Health Services the completed pre-admission screening package. This package includes: (a) the original UAI and DMAS-95 Level I (if appropriate Level II) MI/MR; (b) a copy of the DMAS-96 form; and (c) a copy of the DMAS-20 form; and (d) a copy of the decision letter sent to the individual. The screening team must send the completed screening information to:

   Pre-Admission Screening
   FIRST HEALTH Services
   Post Office Box 85083
   Richmond, Virginia 23285-5083

5. The screening team must retain the original UAI and DMAS-96 and a copy of the decision letter for a period of not less than five (5) years from the date of the screening.

For Home and Community-Based Care Waiver Authorization

Once an individual has been determined to meet nursing facility criteria, the screening team works with the individual to establish the appropriate service authorization for the E&D, CDPAS, or HIV/AIDS waivers. In the case where a documented condition of MI, MR, or RC is present and requires completion of the DMAS-101A and DMAS-101B assessment and after the local community services board (CSB) has returned the completed DMAS-101B evaluation to the screening team, the appropriate services can be authorized.

During the authorization process, the screening team will assist the individual with determining what level of care and services, if any, are needed; who will provide the services; and the setting where services will be provided. If the local CSB has recommended active treatment, the CSB will determine the most appropriate setting for care in order to meet the active treatment needs.

If a DMAS-101B assessment indicates that waiver services cannot be authorized, the screening team and local CSB have the responsibility to confer with the individual about placement options.

The screening team must inform the individual or family of all of the following requirements:

1. That the authorization for Medicaid funded services does not mean that the individual will definitely become financially Medicaid-eligible;

2. That financial eligibility for Medicaid coverage must be determined by an eligibility worker at the local department of social services;

3. That Medicaid cannot reimburse for services unless the individual has been determined to be financially Medicaid-eligible and meets the level of care criteria for

service authorization; and

4. That the individual may have a financial responsibility in the form of a co-payment for Medicaid-funded services, as determined by the eligibility worker at the local department of social services.

Individuals may transition between nursing facility placement and services under either Elderly and Disabled (E&D) Waiver, the Consumer-Directed Personal Assistance Services Waiver (CDPAS) or the AIDS/HIV Waiver without having existing pre-admission screening documents updated or new screenings completed. The admission criteria are the same for the E&D Waiver, the CDPAS Waiver and the AIDS/HIV Waiver as they are for nursing facility placement. For CDPAS there is the additional component to the pre-admission screening process, the DMAS-95 Addendum is required for determination of Cognitive Status if the individual is directing their own care.

Referrals for Waiver Placement

Home and Community-Based Care Waiver services may be considered when the screening team completes an assessment and determines that an individual meets the criteria for nursing facility care and is at risk of nursing facility placement unless additional help is received. Virginia offers Medicaid reimbursement for home and community-based care services through several separate waivers granted by the Centers for Medicare and Medicaid Services (CMS) in accordance with § 1915(c) of the Social Security Act. Section 1915(c) allows CMS to waive certain statutory requirements to allow states to offer those home and community-based care services, which prevent nursing facility placement of Medicaid-eligible individuals.

Virginia offers Medicaid reimbursement for home- and community-based care services through several separate waivers granted by the Centers for Medicare and Medicaid Services (CMS) in accordance with § 1915(c) of the Social Security Act. Section 1915(c) allows CMS to waive certain statutory requirements in order to allow states to offer those home- and community-based care services that prevent the institutionalization of Medicaid-eligible individuals. Continued federal approval for waiver programs is contingent upon the state's ability to document that the population targeted to receive waiver services was, in fact, a population that might have required institutional care and that the cost of home- and community-based care services is equal to or less than the cost of such institutional care. Individuals must be pre-authorized to receive services through one of the approved waivers; there can be no overlap of services between the different waivers.

Virginia offers services through six Home and Community-Based Care Waivers. Four of these waivers require completion of the pre-admission screening process.

1. Elderly and Disabled (E&D) Waiver: Includes personal care, respite care, Personal Emergency Response System (PERS) (cannot be authorized as a stand alone service and may or may not include medication monitoring), and adult day health care services offered to elderly and disabled individuals who would otherwise require nursing facility level of care. This waiver requires pre-admission screening;

2. AIDS Waiver: A waiver offered to individuals with AIDS or HIV and who are symptomatic who would otherwise require hospital or nursing facility level of care. The services include case management, personal care, respite care, skilled nursing, and nutritional supplements deemed necessary by a physician as the individual's primary source of nutrition, consumer-directed personal assistance services and consumer-directed respite care. This waiver requires pre-admission screening;

3. Technology-Assisted Waiver: This waiver includes skilled nursing, respite care, assistive technology, and environmental modifications and is available to technology-assisted individuals under the age of 21 who would otherwise require hospital level of care and individuals age 21 and over who would otherwise require nursing facility placement. The adult population of this waiver requires pre-admission screening;

4. Consumer Directed Personal Assistance (CDPAS) Waiver: A waiver for individuals which includes personal assistance services offered to elderly or disabled individuals over the age of 18, who would otherwise require nursing facility level of care. This waiver requires pre-admission screening;

5. Mental Retardation (MR) Waiver: A waiver for individuals with mental retardation which includes: residential support, day support, prevocational services, supported employment, environmental modifications, assistive technology, respite care, personal care, skilled nursing services, crisis stabilization, consumer-directed personal assistance, consumer-directed respite, consumer-directed companion care, companion care, personal emergency response systems, and therapeutic consultation. Case Management is available to this population as a State Plan Service and not a waiver service. These services are available to individuals who would otherwise require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). This waiver's initial screening is conducted by the local community services board (CSB);

6. Individual and Family Developmental Disabilities Support (DD) Waiver: A waiver for individuals six years and older with developmental disabilities who do not have a diagnosis of mental retardation. Services include: in-home residential support, day support, prevocational services, supported employment, environmental modifications, assistive technology, respite care, personal care, skilled nursing services, companion care, crisis stabilization, assistance care, consumer-directed respite, family/caregiver training, personal emergency response systems and therapeutic consultation. Case Management is available to this population as a State Plan Service and not a waiver service. These services are available to individuals who would otherwise require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). This waiver's initial screening is conducted by the local Child Development Clinics.

Since some waivers offer multiple services, it is a combination of the waiver and the services that are authorized. For example, although an individual authorized for AIDS waiver services may receive personal care, respite care, or both, the screening team will designate only the

Authorization code of #3 "AIDS/ARC Services." The Service Plan will clearly designate which services the individual with AIDS or persons who are HIV+ and symptomatic are authorized to receive.

The determination that an individual can be safely maintained at home with one or more of these services must be based on:

- The needs of the individual;
- The support available to the individual; and
- The availability of a provider for the services deemed medically necessary to avoid nursing facility placement.

Waiver services can only be considered for individuals who meet nursing facility criteria and who are at risk for nursing facility placement.

If an appropriate Service Plan can be developed, the individual must be offered the choice of nursing facility placement or community-based care services. The individual will be asked to document that he or she has been offered the choice between nursing facility and community-based care, the reason that community-based care was not a viable option, and the choice of a service provider on the Service Plan. The team will send a letter documenting its decision to the individual. Examples of decision letters are found in Appendix E.

The screening team must take into consideration the individual's health, safety, and welfare when considering any community placement, including Medicaid-funded home- and community-based care services. If the individual already has an Adult Protective Service worker assigned through the local DSS, this person should be consulted. If the individual's health, safety, or welfare would clearly be jeopardized by a home placement, community-based care must not be authorized. Patients whose medical and nursing needs require intensive nursing intervention need to be considered very carefully since the aide providing in-home care will not be able to provide any of the skilled nursing services.

The screening team must inform the individual of Medicaid Program policies and alternatives, offer a written list of community-based care provider agencies in the area, and have the individual document his or her choice of an agency on that list. The team will document that the individual was provided a choice and identify the agency(s) selected on the Service Plan and on the DMAS-96 form. The screening team must not authorize waiver services when no provider is available. However, a screening team cannot deny a request for a pre-admission screening simply because there is no provider available to provide services.

When the local health department performs the pre-admission screening, it is suggested that the social worker on the screening team be the person designated to offer these alternatives. This will help to alleviate any potential conflict of interest for local health departments that serve dual roles as community-based care service providers and Pre-Admission Screening teams.

The procedure for community-based care approval will differ depending on whether the individual has one or more community-based care services authorized. When multiple service providers are authorized or recommended in the Service Plan, one service provider should be designated as the primary service provider. The primary provider is sent the original copies of

all of the screening documentation and is responsible for communicating with the local DSS Eligibility Section to notify them that services have been initiated for the recipient. The secondary provider(s) is sent a copy of all documentation that the screening team sends to the primary provider by the screening team or the designated primary provider.

AIDS/HIV Waiver

For AIDS/HIV service authorizations, the primary provider should always be the case management provider if the recipient has chosen to receive case management services. If the individual authorized for AIDS/HIV Waiver services does not have a case manager, a direct service provider is responsible for notifying the local DSS Eligibility Section via a DMAS-122 that services have been initiated for the recipient.

The screening team sends the specific forms as outlined in the following procedures:

1. To the primary provider agency: (a) the original UAI; (b) a copy of the DMAS-96 form; (c) a copy of the DMAS-113B form; (d) a copy of the DMAS-20 form; and (e) a copy of the decision letter sent to the individual;

2. To the case management provider for AIDS Waiver services: copies of the DMAS-113B, DMAS-96, and the DMAS-20 forms;

3. The screening team will send a letter to the individual screened with a copy to the referral source indicating the decision of the team. If appropriate, the individual will receive appeal rights within this decision letter giving them instructions on how to appeal the screening team's decision. The individual will also receive the following: (a) a copy of the DMAS-113B form; and (b) a copy of the DMAS-113B form for individuals authorized for AIDS Waiver services;

4. The screening team will send a copy of the completed DMAS-96 form to the appropriate local department of social services, Eligibility Section.

5. Within 30 days of the assessment date, the screening team will send to First Health Services the completed pre-admission screening package. This package includes: (a) the original UAI and DMAS-113A for AIDS waiver recipients; (b) a copy of the DMAS-96 and DMAS-113B forms; and (c) a copy of the DMAS-20 form; and (d) a copy of the decision letter sent to the individual. The screening team must send the completed screening information to:

   Pre-Admission Screening
   FIRST HEALTH Services
   Post Office Box 85083
   Richmond, Virginia 23285-5083

6. The individual's attending physician will receive a copy of the decision letter; and

7. The screening team will retain the following documents for a period of not less than five (5) years from the date of the screening: (a) a copy of the UAI form; (b) a copy of the

DMAS-96 form; (c) a copy of the DMAS-113B forms; (d) a copy of the DMAS-20 form; and (e) a copy of the decision letter sent to the individual screened.

A recipient may desire services above and beyond the services provided by community-based care, which the family or other support system is unable to provide. "Additional services" is defined as those services, which do not usually include tasks covered by community-based care services, such as companion care and heavy household cleaning. The recipient or family may purchase the additional care from any source, including the community-based care agency, or other programs such as Medicare or Title XX.

In summary, community-based care must not be authorized unless all of the following apply:

1. The individual is at risk of nursing facility admission;

2. There are no other services that can meet the individual's care needs in the community;

3. The individual meets the Medicaid nursing facility criteria or the individual is determined to require community-based care to avoid admission to a nursing facility if the individual has a condition of AIDS or HIV; and

4. The overall Service Plan is appropriate and protects the safety, health, and welfare of the individual.

<u>For Elderly & Disabled (E&D) or Consumer-Directed Personal Attendant Services (C-DPAS) Waiver</u>

The screening team sends the specific forms as outlined in the following procedures:

1. <u>To the primary provider agency</u>: (a) the original UAI; (b) a copy of the DMAS-96 form; (c) a copy of the DMAS-97 form; (d) a copy of the DMAS-20 form; and (e) a copy of the decision letter sent to the individual;

2. The screening team will send a letter to the individual screened with a copy to the referral source indicating the decision of the team. If appropriate, the individual will receive appeal rights within this decision letter giving them instructions on how to appeal the screening team's decision;

3. The screening team will send a copy of the completed DMAS-96 form to the appropriate local department of social services, Eligibility Section.

4. Within 30 days of the assessment date, the screening team will send to First Health Services the completed pre-admission screening package. This package includes: (a) the <u>original</u> UAI and DMAS-97 form; (b) a copy of the DMAS-96 and DMAS-101A and 101B forms; and (c) a copy of the DMAS-20 form; and a copy of the DMAS-95 Addendum for CDPAS (if appropriate); and (d) a copy of the decision letter sent to the individual. The screening team must send the completed screening information to:

Pre-Admission Screening
FIRST HEALTH Services
Post Office Box 85083
Richmond, Virginia 23285-5083

5. The individual's attending physician will receive a copy of the decision letter; and

6. The screening team will retain the following documents for a period of not less than five (5) years from the date of the screening: (a) a copy of the UAI form; (b) a copy of the DMAS-96 form; (c) a copy of the DMAS-101A and 101B forms; (d) a copy of the DMAS-20 form; (e) a copy of the DMAS-95 Addendum; and (e) a copy of the decision letter sent to the individual screened.

Authorization and Referral When Services Are Not Required

When the screening team determines that an individual is fully able to care for himself or can be safely and adequately maintained in the home with assistance from relatives, friends, or neighbors and requires no additional monitoring or supervision, the screening team will make no referrals for Medicaid funded long-term care services.

When no referrals for services are required, all of the following procedures apply:

1. The screening team will document this decision on page 12 of the Uniform Assessment Instrument (UAI) and on the DMAS-96 form, indicating that no authorization for Medicaid payment has been approved for this individual. On the DMAS-96 form, #0 "None" would be authorized. An explanation of the reason for the denial must also be documented on the 12th page of the UAI.

2. The screening team will send a letter to the individual screened and the legal authorized representative and a copy to the referral source indicating the decision of the team. The individual will receive appeal rights within this decision letter giving them instructions on how to appeal the screening team's decision.

3. The screening team will send a copy of the completed DMAS-96 form to the appropriate local department of social services, Eligibility Section.

4. Within 30 days of the assessment date, the screening team will send to First Health Services the completed pre-admission screening package. This package includes: (a) a copy of the UAI, (b) a copy of the DMAS-96 form, (c) a copy of the DMAS-20 Consent to Exchange Information form, and (d) a copy of the decision letter sent to the individual screened. The screening team must send the completed screening information to:

   Pre-Admission Screening
   FIRST HEALTH Services
   Post Office Box 85083
   Richmond, Virginia 23285-5083

5. The original UAI and DMAS-96 form and the screening team must retain a copy of the decision letter for a period of not less than five (5) years from the date of the screening.

Authorization and Referral for Non-Medicaid Funded Community-Based Care Services

When the screening team determines that an individual requires assistance in the home and can be adequately maintained by a community service or combination of services, the screening team will initiate referrals. Individual need is stressed from the initial contact through referral and follow-up. Depending upon the type of service required, either the social worker or nurse will make the referral to the appropriate agency and assure that the individual and family understand how to obtain services.

Example: An individual does not have the function or medical/nursing needs for either nursing facility placement or services through one of the home and community based care waiver programs. The individual does have a need for Meals On Wheels; the screening team would not complete a referral for nursing facility or waiver placement, but would complete a referral for other non-Medicaid funded community based services.

It is essential for screening teams to maintain current information on available community resources, such as health services and home-delivered meals, etc., to assist in developing alternatives to long-term institutionalization.

When referrals are made to non-Medicaid-funded community-based care agencies, all of the following procedures apply:

1. The screening team will document this decision on the UAI and on the DMAS-96 form indicating the services that are needed and that no authorization for Medicaid funded long term care services has been approved for this individual. On the DMAS-96 form, #8, "Other Services Recommended," would be authorized and the reason and resources to be used will be documented on page 12 of the UAI. This authorization will also be used for individuals who are referred for active treatment for a condition of mental illness, mental retardation, or related disorders in a mental health setting rather than a nursing facility.

2. The screening team will send a letter to the individual screened with a copy to the referral source indicating the decision of the team. The individual will receive appeal rights within this decision letter giving them instructions on how to appeal the screening team's decision if they so choose.

3. The screening team will send a copy of the completed DMAS-96 form to the appropriate local department of social services, Eligibility Section.

4. Within 30 days of the assessment date, the screening team will send to First Health Services the completed pre-admission screening package. This package includes: (a) a copy of the UAI, (b) a copy of the DMAS-96 form, (c) a copy of the DMAS-20 Consent to Exchange Information form, and (d) a copy of the decision letter sent to

the individual screened. The screening team must send the completed screening information to:

Pre-Admission Screening
FIRST HEALTH Services
Post Office Box 85083
Richmond, Virginia 23285-5083

5. The screening team must retain the original UAI and DMAS-96 and a copy of the decision letter for a period of not less than five (5) years from the date of the screening.

WAIVER SPECIFIC REFERRALS AND SERVICES

Referrals for Case Management Services

Case management services are an integral component of the overall service delivery system for individuals with AIDS or persons who are HIV+ and symptomatic. Virginia offers case management services as a waiver service to enable the continuous assessment, coordination, and monitoring of the needs of the persons diagnosed with AIDS or HIV throughout the term of the individual's receipt of waiver services. Case management services are viewed as an indirect service necessary to the successful avoidance of institutional care for individuals with AIDS or HIV and who are symptomatic. Case management enables the efficient and effective delivery of the other, direct services included in the waiver for individuals with AIDS or who are HIV+ and symptomatic. Personal care, private duty nursing, nutritional supplements, and consumer-directed personal assistance services, consumer-directed respite care, and respite care are viewed as the direct services responsible for the delay or avoidance of institutionalization.

Every individual with AIDS who is HIV+ and symptomatic authorized for waiver services must be offered case management services as an adjunct to other waiver services. Although an individual may refuse case management services and receive only direct services through the AIDS Waiver, the Screening team should encourage use of case management services for every waiver recipient. A Medicaid-eligible individual with AIDS or who is HIV+ and symptomatic may not be authorized for waiver services unless that individual requires the delivery of a direct home- and community-based service (personal care, respite care, private duty nursing, consumer-directed personal assistance services, consumer-directed respite care, or nutritional supplements) in addition to case management.

Due to the episodic nature of the AIDS disease, it is expected that persons with AIDS or HIV will fluctuate in their utilization of direct waiver services as the symptoms abate. They should, however, continue to receive case management services as long as the receipt of case management can be shown to continue to prevent institutionalization.

Referrals for Nutritional Supplements

DMAS will reimburse for physician-ordered nutritional supplements when an AIDS Waiver recipient requires the nutritional supplement as his or her primary source of nutrition and is not able to purchase these food supplements through other available means such as Special

Supplemental Nutritional Program for Women, Infants and Children (WIC) Program, Medicare or Food Stamps. Nutritional supplements are covered as a part of the Virginia *State Plan for Medical Assistance* either as parenteral supplements containing a legend drug, as a sole source of nutrition or through the AIDS Waiver as a primary source of nutrition. Nutritional supplements which do not contain a legend drug are available through Virginia's WIC program which provides vouchers for the purchase of nutritional supplements for children under the age of five or can be purchased with Food Stamps by those individuals whose income falls within the limits established by this federal food program. Due to the prevalence of conditions of wasting, malnutrition, and dehydration, many individuals with AIDS or HIV require nutritional supplements as a component of their health care plans.

Nutritional supplements must be pre-authorized either initially by the screening team or on an ongoing basis by the individual's case manager. The Screening team obtains a physician's order and then completes a Medicaid HIV/AIDS Waiver Services Authorization For Nutritional Supplement form, which shows the type of supplement and amount to be used by the recipient each month (see Appendix D for a sample of this form). The form is given to the recipient to submit to the pharmacy of his or her choice. The pharmacy will bill Medicaid using the pharmacy billing instructions included on the form.

If nutritional supplements (NS) are authorized, the screening team will make referrals for nutritional supplements to DME providers enrolled with Medicaid and must do all of the following:

1. Authorize nutritional supplements on the AIDS/HIV Waiver Service Plan (DMAS-113B form);

2. Obtain the physician's order for nutritional supplements. The order must specify:

    a. The supplement name and type,
    b. The daily quantity to be used by the recipient, and
    c. A quantity of refills not to exceed within a six-month time period; and

3. Complete or obtain a nutritional assessment.

All waiver services must be furnished pursuant to the written Service Plan. The Service Plan will be routinely reviewed and updated at least once every three months by the primary case manager assigned to the individual. The Service Plan will be revised by the case manager or direct service provider as indicated by the individual's changing needs and is subject to ongoing approval by DMAS.

<u>Referrals for Personal Care</u>

Personal care services are available under the following waivers: AIDS/HIV, Elderly and Disabled, Consumer Directed Personal Assistance Services, and Technology Assisted.

Personal care services are defined as long-term maintenance or supportive services which are necessary to enable the individual to remain at home rather than enter a nursing facility. Personal care services may be offered to individuals only through an agency with which DMAS

has contracted to provide personal care. Personal care aides who receive continuous, ongoing supervision from registered nurses including a supervisory visit in the recipient's home at least every 30-60 days render personal care. Effective July 1, 2003, this requirement will change to every 30-90 days. Although personal care aides may provide care to individuals meeting skilled-level criteria, they cannot perform any services not identified in this section of this Chapter.

Supervision is a covered service within the personal care service plan when its purpose is to supervise or monitor those individuals who require the physical presence of the aide to insure their safety during times when no other support system is available. The inclusion of supervision in the service plan is appropriate only when the recipient cannot be left alone at any time due to mental or severe physical incapacity. Individuals who cannot be left alone at any time are typically those who are disoriented and are therefore likely to wander or be a danger to themselves. This would also include individuals who cannot use the phone to call for help due to a physical or neurological disability.

Individuals who have a current, uncontrolled medical condition which would make him or her unable to call for help during a rapid deterioration can be approved for supervision if there is documentation that the recipient has had recurring attacks during the two-month period prior to the authorization of supervision. Supervision cannot be covered if required only because the recipient does not have a telephone in the home or because the recipient does not speak English. Supervision will not be authorized for family members to sleep either during the day or during the night unless the recipient cannot be left alone at any time, secondary to the recipient's severe agitation and physically wandering behavior. The aide services must be required to insure the recipient's safety secondary to a clear and present danger to the recipient as a result of being left unsupervised.

Supervision cannot be considered necessary because the recipient's family or provider is generally concerned about leaving the recipient alone or would prefer to have someone with the recipient. There must be a clear and present danger to the recipient as a result of being left unsupervised. Supervision cannot be authorized for persons whose only need for supervision is for assistance exiting the home in the event of an emergency.

Supervision can be authorized when no one else is in the home that is competent to call for help in an emergency. If the recipient's caregiver has his or her business in the home, such as a day care center, supervision will be considered only if the recipient is dependent in orientation and behavior pattern.

Referrals for Respite Care

Respite care services are available under the following waivers: AIDS/HIV, Elderly and Disabled, and Technology Assisted.

Respite care is defined as services specifically designed to provide an episodic or routine relief to the primary unpaid caregiver of an individual who is incapacitated or dependent due to frailty or physical disability. This definition of respite care embodies the following key concepts:

- A primary unpaid caregiver lives in the home and requires temporary relief from the stress of continual care giving;

- An incapacitated or dependent individual requires continuous and long-term care due to advanced age or physical disability;
- In-home services are designed to relieve the physical and emotional burdens of the caregiver and only secondarily the needs of the care-receiver; and
- Individual or family breakdown and the consequent institutionalization which may result from the physical burden and emotional stress of providing continuous support and care to a dependent individual may be prevented.

This definition distinguishes between respite care and the other services in the continuum of long-term care. The four concepts listed above focus on the need of the caregiver for occasional relief. This focus on the caregiver differentiates respite care from programs, which focus on the dependent or disabled care receiver.

The authorization of respite care is limited to 720-hours each calendar year for the Elderly and Disabled Waiver and the AIDS/HIV Waiver. The authorization of respite care is limited to 360-hours each calendar year for the Technology Assisted Waiver. Reimbursement is made on an hourly basis.

Respite care services are described above in general terminology; however, the same policies and procedures related to respite care are the same whether it is Agency authorized or Consumer-Directed.

Referrals for Adult Day Health Care Services

Adult Day Health Care (ADHC) Services are only available under the Elderly and Disabled Waiver.

ADHC services are designed to prevent institutionalization by providing participants with health, maintenance, and rehabilitation services in a congregate daytime setting. Adult day health care services cannot be offered to individuals who are residents of nursing facilities or adult care residences and adult foster homes approved by the local DSS. Adult day health care cannot be authorized by the Screening team for any individual who is currently receiving non-Medicaid-funded services in an adult day care center setting unless the adult day care center has submitted documentation from the current funding source that states that the current funding will no longer be available. The adult day health care center is responsible for obtaining this documentation for Medicaid-eligible individuals whose coverage for adult day care services has been exhausted and who, in the absence of community-based care, will require institutionalization. The local Screening team must complete the assessment for community-based care services upon receipt of this documentation with a request for screening.

The services offered by the adult day health care center must be designed to meet the needs of the individual participant. Thus, the range of services provided by adult day health care center to each individual may vary to some degree. There must, however, be a minimum range of services available to every Medicaid adult day health care recipient. DMAS will contract only with licensed adult day care centers which have a current and valid license issued by DSS and which

have met additional Medicaid requirements to be adult day health care providers.

Referrals for Personal Emergency Response Systems (PERS)

PERS is an electronic device that allows certain recipients at high risk of institutionalization to secure help in an emergency. PERS electronically monitors recipient safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the recipient's home telephone line.

PERS services are limited to those recipients, ages 14 and older, who live alone or are alone for significant parts of the day, have no regular caregiver for extended periods of time and would otherwise require extensive routine supervision. Recipients must be receiving PERS and another E&D Waiver service simultaneously.

PERS can be authorized when there is no one else other than the recipient in the home who is also competent and continuously available to call for help in an emergency. If the recipient's caregiver has a business in the home, such as a day care center, PERS will only be approved if the recipient is evaluated as being dependent in the category of "behavior patterns and orientation" on the Uniform Assessment Instrument.

Medication monitoring units must be physician ordered. In order to receive medication-monitoring services, a recipient must also receive PERS services. The above information regarding PERS may be found in 12 VAC 30-120-55.

Referrals for Private Duty Nursing Services

Private duty nursing services are available under the AIDS/HIV Waiver and the Technology Assisted Waiver. Private duty nursing may not begin prior to a physician's order for services.

Private duty nursing is professional nursing care provided by a registered nurse or licensed practical nurse in the individual's home or other community setting. This private duty nursing service is authorized when it is necessary to avoid institutionalization by assessment and monitoring of the medical condition, rendering direct care, and communicating with the physician regarding changes in the patient's status.

SERVICE PLAN DEVELOPMENT

A Service Plan must be developed by the screening team that assures the individual's total needs in the community can be adequately provided by a combination of formal and informal supports and that the individual has chosen to remain in the community. The completion of this Service Plan must include input from the individual, the family, and any other support services available to the individual in the community.

The screening team must consider the individual's total needs on a 24-hour-day basis, as well as all the available resources to meet these needs prior to the authorization of Medicaid community-based care. The screening team then determines the waiver services that a provider agency must provide to assure that the individual's health, safety, and welfare are protected.

In developing a Service Plan for waiver services, the screening team must authorize only the services available through a waiver provider and needed by the individual to remain at home with appropriate and adequate care.

Service Needs are defined as follows:

1. **ADL's:** Includes assistance with any of these tasks: bathing, shampooing, skin and nail care, mouth care, dressing, ambulation, transferring, toileting, eating, self-administered medications, turning or changing positions, shaving, hair care, or vital signs;

2. **Housekeeping:** Includes assistance with these tasks: washing dishes; cleaning the kitchen, bath area, and the recipient's immediate environment; making the bed or changing linens;

3. **Meal Preparation:** Indicate only if someone will prepare the meals for the recipient (actual assistance with eating is included in ADL's);

4. **Shopping:** Include only if the recipient lives alone or does not have anyone capable and willing to include the recipient's shopping needs with his or her own;

5. **Laundry:** Include only if the recipient lives alone or does not have anyone capable and willing to include the recipient's laundry needs with his or her own;

6. **Supervision:** Indicate only as a need if the supervision criteria stated earlier in this chapter is met. Complete the Supervision Request (DMAS-100) form and attach it to the Service Plan if the recipient needs supervision time. Since supervision may be the critical component that determines whether the Service Plan will enable the individual to remain at home, the screening team, when necessary, may contact the provider prior to authorizing services to determine if the provider can deliver the services. The provider is ultimately responsible for determining the amount of time to be included into the Service Plan, including supervision; and

7. **Skilled Needs:** Skilled needs may include catheter irrigation, tube feedings, sterile dressing changes, etc., and are not tasks that can be performed by a personal care aide. The type of skilled care and frequency must be noted (e.g., dressing changes 3x/week) as well as the identity of the provider who will render the skilled care.

For any of the service needs, the screening team member may enter a check mark except for noting the number of trips to be provided by adult day health care center.

Under no circumstances should a provider agency receive a referral from the screening team for an individual unless the screening team has confirmed that the provider is aware of the coming referral and can accept the individual for services.

Respite Care Assessment and Service Plan

The screening team must complete the Respite Care Needs Assessment and Service Plan when respite care services are being considered as an alternative to nursing facility care. This assessment and care plan documents:

- Documentation that there is an unpaid live-in caregiver;
- The amount needed; and
- The provider of care.

The Respite Care Needs Assessment and Service Plan do not detail the specific service needs to be provided by the respite care provider. Emphasis is placed instead on the Screening team's documentation of the need for respite care and the overall amount of care required. The respite care provider will develop a task-specific Service Plan based on the functional limitations and nursing needs of the individual as noted on the UAI, the nature of the care required (episodic or routine) as indicated on the Service Plan, and meet with the individual and primary caregiver prior to the start of care.

Medicaid AIDS Waiver Service Plan

Upon completion of the assessment and determination that an individual with AIDS or who is HIV+ and symptomatic meets the criteria for waiver services as outlined in Appendix B of this manual, the screening team will complete a Service Plan which will include all of the following:

- Identification of all services needed by the individual (waiver and non-waiver services);
- Identification and means of contact of all informal support (family, friends, live-in caregiver, support groups, etc.) available to the individual and the type and frequency of support each individual will provide;
- Identification of all non-waiver service providers, whether already providing services or planning to provide services, and the type and frequency of service provided by each;
- Identification of waiver services: the number of units of service authorized, the frequency, the provider(s) chosen by the individual, and the estimated cost of the services to Medicaid. If nutritional supplements (NS) are requested, the Screening team must in addition:

    a. Obtain the physician's order for NS. The order may be written for up to a six-month time period;

    b. Document the supplement name, type, quantity per day, and authorization period (six months from the date of the authorization for AIDS Waiver Services) on the Medicaid HIV Waiver Services Authorization form for Nutritional Supplements; and

c. Give a copy of the Nutritional Supplements form to the recipient to turn into the durable medical equipment (DME) provider of his or her choice. A copy of the form and the physician's prescription must be included in the packet sent to the case management provider (if one is assigned; if not, a copy of the form is sent to the other direct service providers).

The Service Plan must document that the individual was given freedom of choice between institutional and waiver services and that the individual was given a choice of available service providers.

An individual with AIDS or person who is HIV+ and symptomatic must choose a case management provider that meets DMAS criteria for case management provider participation and has a contract with DMAS to render the service. The waiver recipient must be given a choice of service provider. If a case management provider is not available, the screening team should notify DMAS, who will then serve as the case management provider.

MISCELLANEOUS

Cooperation of Responsible Agencies

The functioning of the home- and community-based care services depends on Screening teams, local DSS eligibility workers, home- and community-based care provider agencies, and WVMI. Communication is an essential ingredient in assuring that the policies and procedures of the program are carried out and that provider agencies, eligibility workers, and Screening teams are aware of each other's roles and responsibilities. It is, therefore, imperative that there be open communication and cooperation between Screening teams, local social services departments, home- and community-based care provider agencies, local health departments, Community Services Boards, DMHMRSAS, and DMAS, as well as other entities that DMAS contracts with to perform business functions.

DMAS Authority for Authorization of Medicaid Payment

Screening teams have the initial responsibility and authority for authorizing Medicaid reimbursement for nursing facility and community-based care services. Providers of care are still responsible for requesting authorization for services. In those instances when the assessment documentation does not clearly indicate that the individual meets nursing facility care criteria, Medicaid-covered services cannot be authorized. Any information which is needed to support the Screening team's level-of-care decision must be documented on page 12 of the UAI.

DMAS does, however, have the ultimate responsibility for assuring appropriate placement in nursing facility and community-based care services and thus can overturn any decision made by the screening team. Any authorization made by the screening team is subject to change based on any change that occurs in the individual's condition or circumstances between the time the authorization occurs and the service provider initiates contact with the individual. If, for any reason, the nursing facility or community-based care provider finds that the individual is inappropriate for admission to the service, that nursing facility or provider must notify the individual in writing of the finding and send a copy to both DMAS and the local screening team.

DMAS will review the nursing facility or provider's finding and communicate with the individual and the provider as needed.

In those cases where the individual has been referred for a Level II assessment, the responsibility and authority for the authorization of services is shared with the state MH/MRA and DMAS. The Level II authorization must occur prior to service initiation for nursing facility services.

Freedom of Choice

If the individual qualifies for both nursing facility placement, the Screening team must offer the individual the choice of home and community-based care or a nursing facility. The choice of nursing facility or personal care must be documented on the DMAS-97, Screening Team Service Plan. If the individual selects home- and community-based care, a choice of available home- and community-based care provider agencies will be furnished for selection. This choice is documented on the DMAS-97, Service Plan. The individual's choice between home- and community-based care or nursing facility care and the choice of home- and community-based care provider agencies are federal requirements.

Appeal Rights

The hospital or local screening team, by letter, must inform the individual and the referral source of the pre-admission screening decision to authorize or deny Medicaid payment for long-term care services and indicate the reason(s) for the decision. Any individual wishing to appeal should notify the Appeals Division, Department of Medical Assistance Services, in writing, of his or her desire to appeal within 30 days of the receipt of the Committee's decision letter. The following statement must be included in every decision letter (denial or approval):

> "You may appeal this decision by notifying, in writing, the Appeals Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. This written request for an appeal must be filed within thirty (30) days of the date of this notification."

Any request for an appeal received by the Appeals Division must be validated and a hearing scheduled with the appellant. A final decision on the appeal must be completed within 90 days of the date the request for an appeal is received. The Division of Client Appeals will be responsible for determining the relevant parties to be involved in the hearing process.

Medicaid Contacts for Screening Questions

When Screening teams have questions regarding level-of-care decisions, distribution of forms, or DMAS policies and procedures concerning pre-admission screening, the team should contact the Facility and Home Based Services Unit, at DMAS at (804) 225-4222.

If screening teams wish to share information that might be used in future revisions of this manual, send written suggestions to:

> Supervisor
> Facility and Home Based Services Unit

Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219